COVID Jabs: Ineffective, Oppressive and Dangerous

By Iain Davis | Dec. 22nd, 2021

There is no moral, legal or logical argument for mandatory vaccination. The only logical argument, from a public health perspective, would be either to reduce the spread of infection or reduce the impact on health services via some other mechanism. We will explore the evidence proving that the COVID-19 supposed "vaccines" are incapable of achieving either.

Being aware of the vaccines' ineffectiveness didn't prevent the UK parliament from voting to allow the government to mandate vaccination for NHS staff. In doing so, they laid the path for a wider national mandate. Prior to the vote, the British Medical Journal published the protestation of a concerned medical journalist who highlighted the House of Lords Scrutiny Committee Report that found insufficient evidence to support a mandate for NHS staff.

UK MPs apparently decided that Lords didn't know what they were talking about and weren't interested in the scientific evidence they cited. While this attitude illustrates that their decisions are is not led by science, perhaps this should not be our primary concern.

For, regardless of prevailing political or popular opinions, to insist that individuals must submit to injection against their will is to deny them their inalienable right of bodily integrity. This right was described by Professor David Feldman in "Civil Liberties and Human Rights In England and Wales":

"A right to be free from physical interference. [This] covers negative liberties: freedom from physical assaults, torture, medical or other experimentation, immunization and compelled eugenic or social sterilization, and cruel or degrading treatment or punishment. It also encompasses some positive duties on the state to protect people against inference by others."

Both the European Convention on Human Rights (Article 3) and the Universal Declaration of Human Rights (Articles 1 & 3) allegedly guarantee the integrity of the person. However, these "human rights" are simply words written down by politicians and lawyers. As such, these rights can be overruled by other government officials and attorneys. Thus, "human rights" are not really rights; they are government permits. And permits can be rescinded at any time.

More importantly, in the UK there is a clear legal precedent for the concept of bodily integrity. In Montgomery vs Lanarkshire Health Board the Supreme Court ruled:

"An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken."

If society decrees that its people no longer have a right to bodily integrity, the result is that they become the slaves of that society. A society that advocates mandatory vaccinations is also advocating slavery. Anyone in that society who advocates mandatory vaccination is supporting slavery in principle. No justification can negate this fact.

The legal definition of ownership is:

"The exclusive legal right to possession."

A vaccination mandate decrees that the individual no longer has legal possession of his/her own body. It removes the individual's legal right to ownership of his/her physical being and hands it over to the state. This constitutes slavery.

Slavery is defined as:

"The condition of being legally owned by someone else and forced to work for or obey them."

UK Supreme Court

Some suggest that the "common good" warrants slavery. Their wrong assumptions and ignorance cause them to believe that when a person refuses COVID-19 vaccination, he is putting others at risk and behaving in a way that jeopardises the common good. According to their rationale, society should have the right to violate the bodily integrity of its slaves.

A reminder: mandates differ from laws. Despite that difference, the state uses government mandates to claim a non-existent right to force its citizens to obey. Individuals can be punished—fined or even imprisoned—for failing to abide by a state mandate. The right to bodily integrity is denied by an unlawful mandate, and all citizens are made slaves by virtue of it.

Some anti-rationalists have argued that a mandate does not constitute "force." What a ridiculous contention. Threatening to fine people is coercion, and a warning of potential imprisonment is the threat of violence.

This is the literal definition of the use of force:

"Coercion or compulsion, especially with the use or threat of violence."

Meanwhile, violence is defined as:

"Extremely forceful actions that are intended to hurt people or are likely to cause damage."

Those who believe in the concept of the common good—and contend that it should sometimes override individual sovereignty—accept that some group they choose to empower has the right to force others to obey. Regardless of whatever rationale they claim, though, by insisting that no citizen has the right to bodily integrity, they promote slavery—including their own.

When it is put to them in those terms, though, people are reluctant to admit they are supporting slavery and prefer to pretend that forcing compliance through

other means is *not* slavery. Take Michael O'Leary, the head of Ryan Air. He apparently thinks that denying people access to society, employment, food and medical treatment is not a "mandate" and, therefore, that forcing them to take the vaccine through this withholding mechanism does *not* amount to slavery.

O'Leary's suggestion is that those who decline the vaccine should be punished for their disobedience. He thinks that threatening people with poverty, starvation and a shorter life expectancy is perfectly acceptable in order to force them do as he wishes. He believes that, as long as these threats aren't official mandates, rights remain protected:

"[A mandate] is an infringement of your civil liberties. But you simply make life so difficult. Or [make it that] there are lots of things that you can't do unless you get vaccinated."

Proponents of the "common good" insist that getting vaccinated is the "right thing" and therefore that refusal to comply with vaccination edicts is wrong. But they cannot both proclaim society's alleged authority to ignore the inalienable right of bodily integrity and simultaneously pretend they oppose slavery. If, as a society, we allow the government to mandate vaccines or if, like O'Leary, we choose to enforce vaccination by other means, then we have collectively consented to live in a slave state, where we are all slaves.

Going down this path would condemn future generations to slavery. How odd, then, that society considers selfish those of us who decline to be a slave—who oppose slavery in principle. On the contrary, selfishness is the misguided view that a low-mortality respiratory disease impacts public health and must therefore be put ahead of human freedom.

This opinion is informed by the flawed and irrelevant assumption that by being vaccinated, we protect others. I say "irrelevant" because even if the COVID-19 vaccines were proven effective and safe, and even if we found that our getting jabbed protects those around us, these points would be immaterial—of no consequence. For to deny an individual's right to bodily integrity is slavery—regardless of the claimed justification.

There are already many actual slaves being traded, exploited and abused in the UK. While the experience of those who suffer the daily hell of modern slavery is far worse than merely being forcibly injected with a drug once or twice a year, the principle of slavery is the same. It seems odd that the suggested "common good" doesn't demand freedom for those currently living as slaves. Perhaps society no longer cares.

Recently Health Secretary Sajid Javid, faced with the loss of tens of thousands of NHS staff who were not prepared to submit to government coercion, decreed that the mandate will not be forced upon NHS staff at this time. However, a consultation is underway, and it is possible that mandatory vaccination could still be a prerequisite for professional registration.

Putting aside the lack of moral and legal legitimacy, there are other reasons why we should reject any notion of a vaccine mandate. The primary reason is that the so-called vaccines don't work and are dangerous.

The Jab Basics

The word "infection" is defined as:

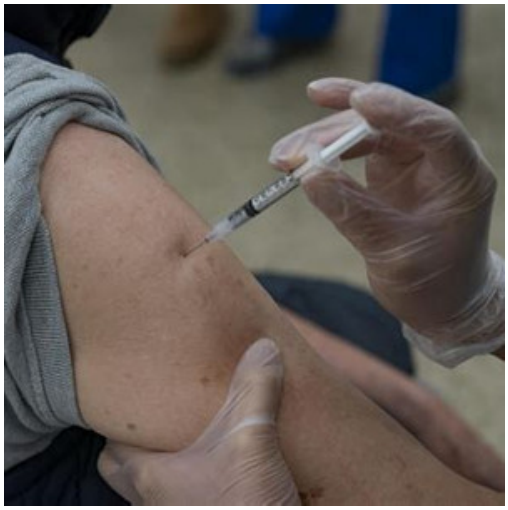
"The state produced by the establishment of one or more pathogenic agents (such as a bacteria, protozoans, or viruses)."

If you had looked at the medical definition of "vaccine" in 2019 you would have understood a vaccine to be:

"A preparation of killed microorganisms, living attenuated organisms, or living fully virulent organisms that is administered to produce or artificially increase immunity to a particular disease."

Immunity used to be defined as:

"The quality or state of being immune; especially: a condition of being able to resist a particular disease especially through preventing development of a pathogenic microorganism or by counteracting the effects of its products."



A vaccine was a drug that "especially" reduced infection. It could theoretically stop a pathogenic agent, such as a bacteria, protozoans, or virus from establishing itself in a biological system. Thus reducing the incidents of disease and subsequent transmission of the pathogen.

However, in the wake of the pseudopandemic, that is not what the changed definition of "vaccine" has come to mean today. The only thing an alleged, so-called vaccine is required to demonstrate is immunogenicity:

"A preparation that is administered (as by injection) to stimulate the body's immune response against a specific infectious agent or disease."

Purely by changing the definition, a "vaccine" is now a drug that stimulates an immune response. It says nothing about how effective or safe that immune response is. Inflammation is an immune response and it is potentially lethal. Absent the ability to protect against infection, most people would consider a drug which only reduces the severity of disease to be a treatment, not a vaccine.

While it is true that language constantly evolves and definitions change all the time, where that change fundamentally redefines the commonly accepted meaning of a word, everyone needs to be aware of the new interpretation. If not, they could accept an implied meaning that no longer exists.

For example, people could easily be fooled into believing a COVID-19 "vaccine" stops infection. To draw a distinction between what most people imagine "vaccine" to mean and what it now means, we will refer to the alleged COVID-19 "vaccines" as jabs.

The Jabs Have Not Completed & Do Not Need To Complete Any Clinical Trials

Unlike every vaccine that preceded them, the jabs have not completed clinical trials prior to being given to more people than any other vaccine in history. At the time of writing there are no results posted for the NCT04614948 trial of the Pfizer-BioNTech mRNA jab; none for the NCT04516746 AstraZeneca jab; there are no results from Moderna's NCT04470427 trial nor any from J&J's NCT04368728 trial of their Jansen jab.

When the UK medicines regulators, the MHRA, said that they "carried out a rigorous scientific assessment of all the available evidence of quality, safety and effectiveness," prior to allowing the jabs' Emergency Use Authorisation (EUA,) they did not mean they had studied the results of any clinical trials. They couldn't, because there aren't any.

What they meant is that they had received interim reports from the manufacturers and their sponsors (UK Research and Innovation, National Institutes for Health Research (NIHR), Coalition for Epidemic Preparedness Innovations (CEPI), Bill & Melinda Gates Foundation, Lemann Foundation etc.). The MHRA, as other regulators around the world, based their decision to grant the EUAs on these interim reports, not upon the results of any clinical trials.

This enables the mainstream media to report news agency statements which mislead the public: "Massive coronavirus vaccine trials involving tens of thousands of participants have so far surfaced no signs of serious side effects."

The continual impression given is that the jabs are clinically proven to be safe and effective. In reality, few adverse reactions have been reported in the trials because no trial results have been posted.

The trials were designed to be blind Randomised Control Trials (RCTs). As they were trialling the first proposed vaccines for a novel disease, the standard RCT approach to determine the safety and efficacy of the jabs was to compare the long-term health outcomes of jab recipients to those of a placebo group. These would be "blinded," meaning that the trial participants were not told if they had been jabbed or had received a placebo.

The secondary outcomes for the trials were designed to assess the effects of the vaccines. This included assessment of any adverse drug reactions (ADRs) for up to two or more years after the final dose. None of the secondary outcomes have been measured yet, because we are more than a year away from the end of the minimum trial periods.

There is now no chance that these clinical trials will ever reveal any meaningful results. As reported in the British Medical Journal, both J&J and Moderna have "unblinded" their trials by giving the jab to their placebo groups. They have abandoned the secondary outcomes years before the trials are complete. When asked, neither AstraZeneca nor Pfizer-BioNTech denied doing the same.

In any event, it appears their trials were poorly designed and lacked scientific credibility. It is strongly alleged that Pfizer-BioNTech, at least, falsified data,

unblinded their study, failed to adequately train staff and were reluctant to follow up on reported adverse events.

When independent researchers used a Freedom of Information request (FoIR) to ask UK regulator, the Medicines and Healthcare products Regulatory Agency (MHRA), why the Pfizer-BioNTech NCT04614948 clinical trial hadn't assessed the vaccine's impact upon pregnant women, the MHRA stated:

"The above trial was not conducted in the UK, the MHRA did not assess its content and are therefore not in a position to answer specific questions relating to it."

Not bothering to consider the primary clinical trial doesn't appear to be a very "rigorous scientific assessment." Rather, it seems the MHRA are among a group of regulators who unquestioningly accepted whatever the manufacturers claim without genuinely scrutinising anything.

The MHRA have now formally adopted this laissez-faire approach to future jab regulation. Having aligned themselves with the Access Consortium of regulators (Australia, Canada, Singapore and Switzerland), the MHRA are among those who see no reason for any further regulatory scrutiny prior to the approval of new jabs.

The Consortium believes new iterations, responding to allegedly new variants of COVID-19, can effectively be waved through automatically. This belief is based upon the impossible.

The MHRA asserts that their initial EUA reflected their appraisal of the "pivotal clinical trials," for which there are no posted results. Having authorised the jab roll-outs without any substantiating evidence, the MHRA now claims that, for all tweaked future versions:

"Clinical efficacy studies prior to approval are not required. Regulatory Authorities request bridging data on immunogenicity from a sufficient number of individuals"

This speeds up the process of getting jabs straight out of the corporate labs and into the arms of a broadly misinformed public. Whatever tweaks the manufacturers choose to make will just be rubber-stamped by the Consortium as long as the pharmaceutical corporations submit the appropriate immunogenicity claims.

The issuance of an EUA is not the same as regulatory approval of a medicine. As explained by the US regulatory agency, the Food and Drug Administration (FDA), an EUA is a temporary authorisation of an investigational medication:

"An EUA for a COVID-19 vaccine may allow for rapid and widespread deployment for administration of the investigational vaccine to millions of individuals"

The FDA also states that an investigational drug, still in trials, is an experimental drug:

"An investigational drug can also be called an experimental drug."

The current COVID-19 jabs are still in trials and are "experimental drugs." So-called fact checkers have been dispatched to mislead the public into believing this is not the case. For example, Full Fact, the UK-based political activists who work with policy makers to market their own business, claimed:

"The three Covid vaccines currently approved for use in the UK have already been shown to be safe and effective in clinical trials."

This was a factually inaccurate statement. In terms of issuing EUAs, all that was known from the phase 3 trials was the interim results. These reported what little data was available from the first two months of phase 1. This was merely a claim that the jabs were relatively safe for a small cohort of fit and healthy, predominantly younger people. We will shortly discuss why even this assertion is false.

All we can say at this juncture is that there is no perceptible regulation of the jabs. They are effectively unregulated.

The trials have yet to demonstrate that the jabs are either safe or effective. The exclusion criteria for all the trials ruled out trialling the jabs on those most vulnerable to COVID-19. The interim reports from phase 1 claim efficacy and safety only among those least susceptible to apparent COVID-19 risks. Now those trials will never be completed.

The interim trial reports claimed efficacy in terms of relative instead of absolute risk reduction. This enabled the manufacturers to claim a 95%+ reduction in mortality (efficacy). That distorted percentage was then reported to the public, who were swayed by the reporting bias.

In fact, the claimed absolute risk reduction (efficacy) was typically less than 1%. Had this been reported to the public, people would have been less enthusiastic and perhaps more sceptical about the jabs—which is precisely why it wasn't reported.

On both sides of the Atlantic, the EUAs came with immunity from prosecution for the manufacturers. In the UK, the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 extended the liability protection offered to administering medical practitioners to the pharmaceutical corporations.

Immunity from prosecution is an apparent deal breaker for the drug companies. In early 2021 the managing director of the World Bank, David Malpass, reported that some jab manufacturers would not distribute their jabs to countries that did not fully indemnify them against prosecution:

"The immediate problem is indemnification. Pfizer has been hesitant to go into some of the countries because of the liability problems; they don't have a liability shield. So we work with the countries to try to do that."

There is no doubt that the jabs are experimental drugs that have not completed any clinical trials. As such, the recipients are part of a global medical experiment

being conducted by a partnership of governments and global pharmaceutical manufacturers that have no liability for any harm they may cause. This fact is then covered up by the global media corporations and the appointed fact checkers who, like the pharma companies, also work in partnership with government.

Statements from the NHS such as "The COVID-19 vaccines are the best way to protect yourself and others" or "Any side effects are usually mild and should not last longer than a week" are not based upon any clinical trial evidence. Rather, they are speculative, misleading and potentially dangerous proclamations.

Unless, before being jabbed, recipients were explicitly made aware of these facts they cannot possibly have given informed consent. In each and every instance, despite the fact-free denials of the comically misnamed fact checkers, this constitutes a breach of the Nuremberg Code.

Blaming the Unjabbed

Following the comments of the health secretary, Sajid Javid, the MSM dutifully reported that there are around 5M "unvaccinated" people in the UK. This figure appears to be only partially accurate.

According to figures released by the UK Health Security Agency (UKHSA), by mid-December 2021, when the booster rollout was well underway, around 38.6 million of the approximate 44.6M adults in England had received at least two doses and were therefore temporarily deemed to be "fully vaccinated."

This means that currently about 6M adults in England alone are officially "unvaccinated." England represents approximately 84% of the entire UK population. Assuming similar vaccine distribution figures for the whole of the UK, this suggests that at least 6.9M adults—nearly 13% of the adult population—are officially unvaccinated.

The size of the unvaccinated population is set to grow. The UK government has already said that a booster will be needed in order to obtain an NHS COVID Pass

for international travel. Initially the UK government said it didn't intend to extend this certificate to domestic travel, but, then again, the same government repeatedly denied it would ever introduce vaccine passports, period!

Subsequent comments from the Health Secretary clarified the government's intention to continually shift its definition of "fully vaccinated." To be fully vaccinated, the slave must always agree to the next jab. With the jab sales force insisting that boosters will be needed for years to come, it seems "fully vaccinated" status will last for only about six months.

The MSM, on behalf of their government funders, have propagandised the nation into believing that it is the unvaccinated who are "overwhelming" health services. With headlines like ICU is Full Of The Unvaccinated – My Patience With Them Is Wearing Thin, it is no wonder that the jabbed majority are turning their hate towards the people who don't want the jabs. For example, social media comments such as this one are common:

"Unvaccinated people are taking beds from other sick people, some of whom become sicker as a result. Not being vaccinated during a pandemic is an act of selfishness hiding behind the facade of individual liberty."

The "ICU is Full" *Guardian* article was from an anonymous source. No one was willing to put their name to it. It was primarily an appeal to emotion and offered no evidence to back up any of its claims. This is because the evidence does not support any aspect of the published story. The only apparent reason for the article was to incite hatred.

Real journalists, like Kit Knightly from *OffGuardian* (which is censored by the social media platforms), have been willing to use their byline to report the facts —such as the fact that ICUs are not overwhelmed at all. They are quite busy, as usual, but they are certainly not overrun with COVID-19 "cases," as the *Guardian* and others have deceptively claimed.

Currently there are 4,330 critical care beds in England. On December 14, 2021, 925 of these beds were occupied by so-called COVID-19 patients. That's a

COVID-19 ICU bed occupancy rate of 21.4%. There were 775 (17.9%) unoccupied ICU beds and 2,657 beds (61.4%) taken by patients who had *not* tested positive for the selected COVID-19 nucleotide sequences.

In their Week 50 Vaccine Surveillance Report, UKHSA states that, for the preceding four-week period, 2,965 alleged COVID-19 adult hospital patients had not received a jab, and 4,557 had received at least one. Therefore, UKHSA claims that the unjabbed represent 39.4% of total COVID-19 hospital admissions.

Sajid Javid

For the same four-week period, UKHSA also reported that 715 of the 3,083 total adult deaths, within 28 days of a positive test, were people who were not jabbed. This represents 23.2% of alleged COVID-19 deaths. According to the agency, 28 deaths were attributed to those with an unknown jab status and the remaining 2,340 were jabbed. The jabbed represent 76% of all alleged COVID-19 deaths.

Similar data for Wales also belies the false claim that it is the unjabbed who are "overwhelming" health services. In November 2021, 12.8% of hospital inpatients were "unvaccinated." The "vaccinated" accounted for 84.5% of hospital inpatients; another 2.7% had an unknown jab status.

The anonymous claims reported in the *Guardian* weren't even remotely accurate. The tale was a propagandist disinformation. It was "fake news."

Yet the politicians are desperate to peddle the same lie, with the assistance of their compliant MSM. Once again, the *Guardian* reported the comments of the Health Secretary as if they were realistic. Speaking about the people who have considered the evidence and have decided not to take the jab, Javid said:

“They must really think about the damage they are doing to society. They take up hospital beds that could have been used for someone with maybe a heart problem, or maybe someone who is waiting for elective surgery.”

At no point did the fearless journalists at the *Guardian* inform the public that what he was saying was total nonsense. Instead, they doubled down on the lies with added disinformation of their own, claiming that “nine out of 10 of those needing the most care in hospital are unvaccinated.” Yet another example of absolute fake news, intended to deceive the public.

As we will discuss shortly, it is the seeming clamour to “get boosted,” incessantly pushed by the MSM and the politicians, effectively shutting down primary healthcare, that presents a far greater risk to public health. The mendacity of Javid’s disinformation is breathtaking.

The people who are queuing for their jabs aren’t selfish, just misinformed. However, the 13% of the adult population who don’t want one aren’t selfish either.

The MSM and the politicians persistently try to drive a wedge between the jabbed and the unjabbed. They seek to cause divisions based upon disinformation, lies and propaganda.

The reason for this is clear. Just like all tyrannical regimes throughout history, the public and private partners in the current UK dictatorship wish to scapegoat a minority in order to avoid wider public attention turning on them. They do this to reduce the chance of the people questioning the tyrants who are enslaving them. It is nothing more complex than divide and rule.

The Jabs Don’t Work

Speaking in October, UK Prime Minister Boris Johnson effectively admitted that the jabs are not “vaccines”—that they do not function like any vaccines we are familiar with. Apparently, they are much more like a treatment:

"Double vaccination provides a lot of protection against serious illness and death but it doesn't protect you against catching the disease, and it doesn't protect you against passing it on."

Johnson's observation was partially accurate. Recent research from the US found that there was no difference in viral load between the vaccinated and the unvaccinated. These findings appear to be corroborated by a study from Singapore, which strongly advocated the jabs for their claimed ability to reduce mortality but which also noted:

"PCR cycle threshold (Ct) values were similar between both vaccinated and unvaccinated groups at diagnosis, but viral loads decreased faster in vaccinated individuals. [. . .] [V]iral load indicated by PCR Ct values was similar between vaccinated and unvaccinated patients."

For the jabs to function as a vaccine, in the traditional sense, the higher the jab rate, the lower disease prevalence should be. This is an obvious point, but seemingly one that needs to be stressed, as the wider public appears to be largely unaware of this.

But with the COVID-19 product, there is no statistical correlation between population jab rates, infection rates and disease prevalence. A joint US and Canadian study, which assessed statistical reports from 68 countries and 2,947 US counties, found:

"At the country-level, there appears to be no discernible relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days. In fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people."

Yet, somewhat contrary to their own findings, the researchers still promoted the jabs as part of broader approach to disease mitigation using non-pharmaceutical interventions, including wearing face masks, implementing lockdowns and

practicing social distancing. As we will discuss shortly, promoting the official narrative is now a prerequisite for peer review and publication.

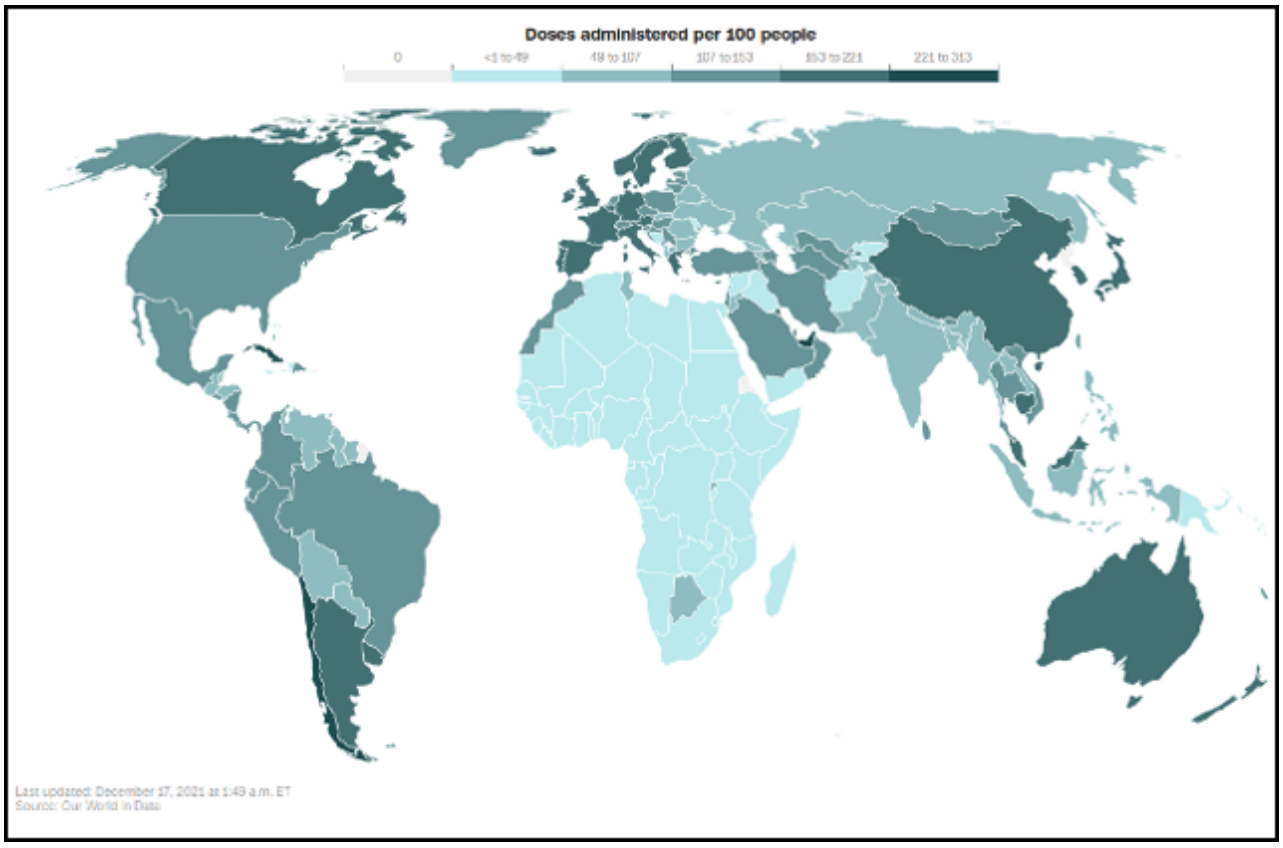
Presumably, to stay within the permitted boundaries of the official scientific consensus, the researchers maintained the new definition of "vaccine," describing a drug incapable of reducing infection rates that acts like a treatment this way:

"Vaccinations offer protection to individuals against severe hospitalization and death."

The peninsula of Gibraltar, with a population of around 34,000, was delighted to declare that it had achieved a 100% jab rate. Thereafter it suffered a surge in reported cases. In the Republic of Ireland, the city of Waterford has a 99.7% jab rate and the highest case rate in Ireland.

In Israel, where the definition of "fully vaccinated" means someone received two initial jabs and a booster (three jabs), there have been 67 recorded cases of the Omicron variant. Of these, 54 (nearly 81%) were fully jabbed. Of the remaining 13 cases, we don't know if any of them were genuinely unjabbed. They could have received one or two jabs and still have been categorised as not "fully vaccinated."

If we look at a recent map of vaccine coverage provided by CNN, we can identify some interesting comparisons. Brazil, with jab coverage of 150 jabs per 100 people, has more than 103,000 COVID cases per million people (CPM). Neighbouring Bolivia, with 77 jabs per 100, has a case rate of just under 47,000 CPM. Paraguay has a slightly higher jab rate of 88 and a slightly higher case rate of 64,000 CPM. Argentina, with the highest jab rate of all, at 220 per 100, also has the highest CPM of all, at just over 117,000.



The most striking feature of the CNN map is the very low vaccinations rates in Africa. Nigeria, Tanzania and Zambia, for example, have less than 10 jabs per 100. They are among the countries with the lowest case rates in the world. Zambia has just over 11,000 CPM and Nigeria and Tanzania much less. By contrast, Botswana, with a relatively high African vaccination rate of 62 per 100 people, has a CPM of nearly 82,000.

Some scientists are apparently mystified by the low rates of COVID-19 in Africa as a whole. They offer a range of possible explanations. They point to a younger population, to early border closures, to lower urban density and to possibly more outdoor activity to account for the obvious anomaly. Calling it a "mystery," Prof. Wafaa El-Sadr, global health lead at Columbia University, said:

"Africa doesn't have the vaccines and the resources to fight COVID-19 that they have in Europe and the US, but somehow they seem to be doing better."

African nations are certainly doing better than the US. With approximately 4% of the world's population and a vaccine rate of 147 per 100 people, the US account for more than 36% of the current 27,586,743 active global cases. In fact, the list of

the top 20 nations with the highest case rates around the world is predominantly composed of the countries with the highest vaccination rates.

Scientists are looking at all the variables to try and figure out what could possibly explain the African mystery. The only factor they aren't considering is the most obvious one.

Despite most African nations having no first wave, the global scientific and medical authorities are hell-bent on preventing the second with the jabs. Prof. Salim Abdool Karim from the South Africa's University of KwaZulu-Natal said: "We need to be vaccinating all out to prepare for the next wave."

Prof. Karim was invited to join the World Health Organisation's (WHO) science council in April 2020. The WHO has made jabbing African populations its next priority.

There are multiple studies demonstrating that natural immunity derived from infection is considerably better than any imparted by the jabs. A recent Israeli investigation suggests that natural immunity, following infection, is up to 27 times more robust than any immunity conferred by the jabs.

Regardless of scientific debates about antigens, T-cells and immunogenicity etc., which all relate to how the jabs supposedly function, very basic statistical analysis is sufficient to clearly demonstrate that they do not work as vaccines. The only remaining claim for the jabs' efficacy is that they reduce hospitalisation and death. Unfortunately, there is a lot of evidence which casts doubt upon this claim too.

Anthony Fauci (left) & Salim Abdool Karim (right)

If the jabs are incapable of stopping infection and transmission and serve only to reduce natural immunity, there is no possible public health rationale for a jab mandate. An uninfected individual is no more likely to catch COVID-19 from an unjabbed person than they are from a jabbed citizen. According to the official definition of a COVID-19 case, the statistics show that the jabs don't make any difference whatsoever to the spread of disease.

In his more recent address to the nation, in which he push the unregulated booster jabs, Boris Johnson said:

"Over the past year we have shown that vaccination is the key to beating Covid and that it works. [. . .] It is now clear that two doses of vaccine are simply not enough to give the level of protection we all need. [. . .] [W]e must urgently reinforce our wall of vaccine protection to keep our friends and loved ones safe. [. . .] As we focus on boosters [. . .] it will mean some other appointments will need to be postponed until the New Year. [. . .] If we don't do this now, the wave of Omicron could be so big that cancellations and disruptions, like the loss of cancer appointments, would be even greater next year."

Johnson's speech was utterly incoherent. On the one hand the vaccines work but on the other they don't and a booster is required. To fend off a wave of cases, defined by a test that can't identify cases, apparently trivial health interventions,

like cancer screening appointments, need to be cancelled for the benefit of the nation's health and the common good.

Shortly following Johnson's plea to "get boosted now" the UK government clarified that GP surgeries across the land would focus upon jabs and emergency appointments only. By declaring a "national mission" to jab as many people as possible, primary care has practically been suspended in the UK. This has been done in the winter, in the middle of an alleged respiratory disease pandemic. The health impact from this will be disastrous.

The British Medical Association has already warned that the reconfiguration of the NHS, first into a COVID-19-only service and now a jab-only service, has terrible public health consequences. Just in the three-month period following the first lockdown, there were up to 1.5M fewer elective admissions to hospital; first-time patient attendance, for all conditions, dropped by 2.6M; urgent cancer referrals were down by an alarming 280,000, with up to 26,000 fewer patients starting treatment, of which 15,000 would normally have first come to light via a GP referral.

Yet, knowing all this, the government would have you believe that their intention is to save life. This claim is not credible.

The Jabs Are Dangerous

Further evidence from Israel suggests that the period between the first and second jab, and shortly thereafter, increases the COVID-19 mortality risk. Vulnerability to disease is significantly greater during this three-to-five-week period.

Prof. Dr. Seligmann (PhD) and his research partner calculated the base rate likelihood of COVID-19 mortality for different age groups prior to being jabbed. For example, for those over 60, it was 0.00022631% per day. He then contrasted this with the official Israeli data for mortality immediately post jab.

During the 13-day period after the first dose of the Pfizer jab, the COVID-19 daily mortality risk for the over 60s was 14.5 times higher at 0.003303% per day. After 13 days this risk increased to 0.005484% per day, more than 24.2 times greater. This rose further, up to six days after the second dose, to 0.006076% per day, representing a 26.85-fold increased risk of COVID-19 mortality for the jabbed.

Prof. Seligmann found similarly huge increases in the COVID-19 mortality risk for all the jabs during what he called the "period of vaccination." Once the recipients were "fully vaccinated," Seligmann found some benefit for the jabbed, as they afforded a marginal reduction in COVID-19 mortality risks when compared to those of the unjabbed.

He calculated that, for this benefit to outweigh the massive increase in risk during the "period of vaccination," the jabs would have to provide near 100% protection for more than two years just to offset the initial health cost of being jabbed. This benefit is not seen in the data.

A recent Swedish study is one among many to show that any possible COVID-19 benefit, once fully jabbed, wanes quickly. Unable to protect those most vulnerable to COVID-19 after six months, Dr Seligmann's research indicates that there is no COVID-19 health benefit associated with the jabs.

Official risk/benefit analysis suggests that being fully jabbed provides some marginal protection against hospitalisation. There is also a barely discernible statistical signal suggesting that being fully jabbed also reduces mortality, though to a very limited degree.

Prof. Seligmann found the same. However, this related only to the COVID-19 statistics and is based on non-diagnostic RT-PCR test results. Official claims take no account of the additional "period of vaccination" risk identified by Seligmann.

Prof. Selligman and Dr. Spiro P. Pantazatos, assistant professor of clinical neurobiology at Columbia University, subsequently undertook further evaluation of the all-cause mortality risk following the jabs. Their research showed an estimated US Vaccine Fatality Rate (VFR) of 0.04%, suggesting that the CDC-

declared VFR of 0.002% underestimates mortality caused by the jabs by a factor of 20. The scientists found that the data indicated US jab-related deaths of between 146,000 and 187,000 for the period between February 2021 and August 2021.

Pantazatos and Seligmann also identified a significant increase in the all-cause mortality risk in the first five-to-six weeks following the first jab. Again, they demonstrated that the initial risk of being jabbed is not offset by the short-lived benefit once "fully vaccinated."

There is little reason to accept the officially reported statistics. The attribution of COVID-19 to mortality is spurious. Though death within 28 or 60 days of a positive RT-PCR test is used—the number of days depending on whose statistics you look at—this is *not* "proof" that COVID-19 was the cause of death.

Attribution of COVID-19 to hospital admissions is equally weak. Research by independent auditors shows that people with a range of non-COVID related presentations, such as limb or head injuries, are often admitted to hospital as supposed COVID-19 patients. The researchers found that, in more than 90% of alleged COVID-19 admissions, there was no clinical reason to describe them as such.

All alleged benefits of the jabs are based upon these woolly definitions and questionable statistical assertions. Consequently, if we truly want to understand the possible benefits of the jabs, we need to look at all-cause mortality. This can be considered more reliable because it is simply an analysis of all registered deaths, irrespective of the cause.

If the jabs work and are safe, then a difference in all-cause mortality between the jabbed and the unjabbed should be observable. While the jabbed aren't protected against other causes of death, they are supposedly protected against COVID-19, and this should be detectable in the data.

A team of statisticians from Queen Mary University London conducted a study of all-cause mortality data in England. They examined the vaccine surveillance

monitoring reports issued by the Office of National Statistics (ONS). They noted that initially, as we've discussed, these official reports seem to show a benefit from the jabs. However, they identified a series of anomalies in the data.

They found that non-COVID-19 mortality patterns for the supposedly unjabbed had peaks that correlated with jab rollouts. After the "period of vaccination," the non-COVID-19 mortality for both the jabbed and allegedly unjabbed cohorts remained similar and relatively stable. Further, in general, the unjabbed appeared to have unusually high non-COVID-19 mortality while the jabbed seemingly had unusually low non-COVID-19 mortality.

They also looked at the different categories of jabbed people. These were "within 21 days of first dose," "at least 21 days after first dose," and "second dose." They found a consistent but large variation in the mortality figures between these groups. "Second dose" non-COVID-19 mortality was persistently below baseline mortality, while "within 21 days" mortality was always far above baseline.

Most striking were the different patterns in mortality between the three studied age groups. Historical data shows that for those in the 60–69, 70–79 and 80+ age groups, while all-cause mortality increases with age, the three groups always shared the same mortality distribution pattern, typically with a peak in the winter months. This is often referred to as "excess winter mortality."

Yet in 2021, not only did the three groups have separate periods of peak mortality, dispersed unseasonably throughout the year, but for the unjabbed that mortality corresponded directly with the jab rollouts in each age group. Nor did these peaks in unjabbed mortality corrolate to supposed waves of COVID-19. They followed the jab rollouts.

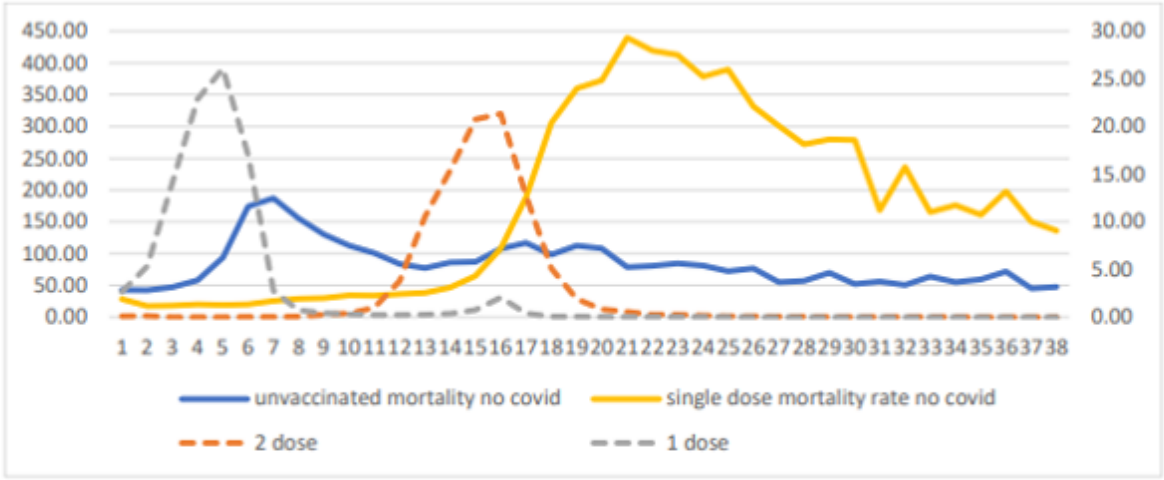


Figure 13: Non-Covid mortality rate in unvaccinated and unvaccinated versus % vaccinated in age group 70-79 (weeks 1-38, 2021)

The researchers concluded:

"Whatever the explanations for the observed data, it is clear that it is both unreliable and misleading. [. . .] [W]e believe the most likely explanations are systematic miscategorisation of deaths between the different groups of unvaccinated and vaccinated; delayed or non-reporting of vaccinations; systematic underestimation of the proportion of unvaccinated [and] incorrect population selection for Covid deaths. With these considerations in mind we applied adjustments to the ONS data and showed that they lead to the conclusion that the vaccines do not reduce all-cause mortality, but rather produce genuine spikes in all-cause mortality shortly after vaccination."

The head of the research team, Prof. Dr. Norman Fenton, gave a radio interview in which he explained why his paper had not been peer-reviewed or submitted to a journal for publication:

"The unvaccinated seem to be dying after not getting the first dose and the single dose are dying after not getting the second dose. [. . .] [T]he vaccinated are dying within 14 days of vaccination and are simply being categorised as unvaccinated. [. . .] There is no evidence for their efficacy when it is measured by the only sensible way to measure it, which is all-cause mortality. [. . .] When we first started doing research on this, we had no problem getting our work into peer-reviewed papers, because we weren't challenging the narrative. [. . .] As soon as it

became clear, you know, with the sort of mass testing of asymptomatic people, that the potential for false positives for asymptomatics was inflating case numbers and COVID so-called hospitalisations and deaths, as soon as we started raising those concerns in our work, as soon as we submitted it for publication, it was being rejected without review. Something I have never had before."

Rejecting science, because it doesn't abide by the official narrative, is not a new problem but it is "anti-science" and suggests a coordinated effort to deceive. The work of Prof. Seligmann and others, looking at both COVID-19 and all cause mortality, appears to independently corroborate the finding of Queen Mary team.

There is no doubt that the jabs can kill. There have been a number of inquests that have found that death was caused by complications following the jabs. Causes of death have included venous infarction thrombosis, intracerebral haemorrhage, anaphylaxis, vaccine-induced thrombosis & thrombocytopenia and "unrecognised consequences of elective COVID-19 vaccines," to name a few. The only question is the scale of the mortality caused by the jabs.

US researchers found a 19-fold increase in myocarditis (heart inflammation) among the 12-to-15-year-olds, which directly correlated with the jab rollout. The study was peer-reviewed and then published, before being withdrawn by journal editors without explanation. Myocarditis is extremely serious for young people and often requires a heart transplant in later life, significantly reducing their life expectancy.

Just as some in the scientific community are mystified by the almost-perfect correlation between jab and COVID-19 "case" rates, so the medical profession is similarly bewildered by the marked rise in cardiac emergencies in Scotland. These, too, followed the jab rollout for the impacted age groups. Apparently doctors haven't got the faintest idea what the cause could possibly be. They are not investigating if it could be the jabs.

Why they aren't investigating could be seen as yet another mystery, because the statistical evidence indicates that the jabs are lethal. If we look at statistics from

the ONS, it is evident that, between January and October 2021, the jabbed under-60s in England were dying at approximatly double the rate of the unjabbed.

This is not an insignificant fact, but it comes with important caveats. Prof. Fenton and his team did not analyse this age group because it is too broad. Depending on the progress with the jab rollouts, with older people jabbed first, the jabbed cohort is likely to have a higher baseline mortality risk than the jabbed.

Taken in isolation, this statistic doesn't reveal much. It is more telling in the context of a German study that also found a clear correlation between the jabs and mortality. Together, these add further corroboration to the other statistical findings we've discussed. The German scientists, Prof. Dr. Rolf Steyer and Dr. Gregor Kappler, concluded:

"The higher the vaccination rate, the higher the excess mortality. In view of the forthcoming policy measures aimed at reducing the virus, this figure is worrying and needs to be explained if further policy measures are to be taken with the aim of increasing the vaccination rate."

June Raine: MHRA chief executive

The only rationale that can explain how the ONS, MHRA, EMA, FDA and other official bodies around the world are maintaining the lie that the jabs save lives is that they have chosen, or have been ordered, to release disinformation that they know endangers public health. There is yet more evidence from the clinical trials that this is the case.

The FDA, MHRA, EMA and other supposed regulators granted EUAs for the Pfizer/BioNTech jab based upon a mere two months of extremely limited interim trial data. Research by the Canadian COVID Care Alliance has exposed this wholly untrustworthy process. There was no mention in the original interim trial data, submitted by Pfizer, of the scale of the ADRs caused by their product.

Using relative risk, Pfizer claimed their jabs were amazing. Nearly everyone, including the regulators, simply took the vaccine-maker's word for it. Those who didn't were vilified as "covid deniers" or "anti-vaxxers."

Six months into the jab rollout Pfizer released more data with another interim study. They made more claims about the efficacy and safety of their BNT162b2 jabs:

"BNT162b2 continued to be safe and have an acceptable adverse-event profile. Few participants had adverse events leading to withdrawal from the trial."

However, this wasn't true at all. In their released report, published by "respected journals" like the Lancet, they forgot to analyse the supplementary evidence concerning ADRs, also contained within their findings.

This revealed a consistent elevated risk of Adverse Events (AEs) for the jabbed. For example, "related events" are adverse health events that are deemed to be caused by the jab. For the jabbed, the related risk ratio was 23.9, for the unjabbed it was six. This is nearly a 300% increase in the risk of health harm if you take the Pfizer jab.

Serious adverse events are likely to put you in hospital. For the jabbed the risk was 0.6, for the unjabbed it was 0.5. In other words the jab increases your risk of being hospitalised by 10%.

A drug that increases illness in the population is not an "effective vaccine." Reducing "case numbers" for one ailment is an utterly pointless exercise if population levels of illness and hospitalisation increase as a result. It gets worse.

Prior to unblinding their own trials, thereby ending the supposed RCTs years before completion, jabbed and unjabbed cohorts were almost equal in size. While 15 people died in the jabbed cohort, 14 died in the unjabbed cohort. *Following* unblinding, a further five jabbed people died, including two who were previously unjabbed.

The logical conclusion from these trials is that the jab increases the mortality risk. And this is precisely what Seligmann, Fenton, Steyer, Kappler, Pantazatos and many other scientists and statisticians have observed and reported.

Pfizer was eager to report the 100% reduction in COVID-19 mortality in the main body of their study. Of the 21,926 people in the jabbed cohort, only one died with a positive RT-PCR-confirmed COVID-19 "case," whereas two of the 21,921 placebo group died. Hence Pfizer's "100% improvement" claim of efficacy.

The drug company, however, failed to mention that its product doubled the chance of you suffering a cardiovascular event after the jab. And it definitely shied away from the most unpalatable reality of all—namely, there were four heart attack deaths among the jabbed compared to only one in the placebo group. In other words, a 300% increased risk of fatal heart failure following the jab.

If the objective of the jabs is to "save life," then it is impossible to understand how these vaccines ever received EUAs. Fully indemnified against prosecution and with carte blanche from the regulators to do whatever they like, the pharmaceutical corporations armed with these EUAs are fully committed to jabbing all our children, including infants.

This attack on our children is something our governments and the majority of the population wholeheartedly approve of. If you question it, you are called "selfish."

The Regulators Seeming Efforts To Hide The Truth About The Jabs

It is common to read claims from the regulators, and from everyone else who advocates the jabs, that the benefits of the vaccines outweigh the risks. These claims are based on two factors: the alleged risk of COVID-19—a risk practically impossible to assess due to the massive corruption of the data—and a blanket refusal to consider that any risks come from the vaccines.

At first glance, the safety profiles for the jabs look appalling. So far, in the UK alone, there are 1,822 possible jab-related deaths recorded via the MHRA Yellow Card scheme. In response to a Freedom of Information Request (FOIR,) the MHRA revealed that it had received:

"[. . .] a total of 404 UK spontaneous suspected ADR reports for any vaccine between 01/01/2001 – 25/08/2021 associated with a fatal outcome."

Compare 404 fatalities caused by all vaccines over 20 years with more than 1,800 suspected fatalities already reported from the COVID vaccines alone. This means the latter potentially accounts for three and a half times more fatalities than all other vaccines combined over the last two decades! This is a statistical pattern repeated in every nation that has rolled out the COVID injection scheme.

We also know that the vast majority of possible ADRs remain unreported. A 2018 survey study of paediatric healthcare professionals found that 64% had not reported known ADRs. Of the total surveyed, 16% didn't even know about the existence of the Yellow Card system, and 26% didn't know how to use it, with only 18% having undertaken any relevant training. So it is not at all surprising that the MHRA states:

"It is estimated that only 10% of serious reactions and between 2% and 4% of non-serious reactions are reported."

There is no evidence that the MHRA have done anything to improve Yellow Card reporting. Though it has apparently promoted the Yellow Card Scheme, no one has noticed. With nearly 400,000 COVID jab ADR reports in the system already, it is likely that the true figure is in excess of 10 million serious reactions. And UK deaths caused by the jabs could certainly exceed 18,000.

These figures are necessarily speculative to a degree, because the MHRA has not investigated any of the recorded ADRs. That agency has no idea how many people have been killed by the jabs and has shown no interest in finding out. While it claims its role is to investigate potential ADRs, to provide an "early warning

system" for possible vaccine harm, from the other side of its mouth the MHRA is saying:

"The suspected ADRs described in this report are not interpreted as being proven side effects of COVID-19 vaccines."

That position might be reasonable if the reports of harm were then investigated. But that's *not* what the MHRA does. Thus, its stance and statements have been wholly *un*reasonable.

To date, the MHRA has provided nothing that proves these reports are not evidence of ADRs. Simply saying that the reports provide no proof of their claims is meaningless. Nothing can be proven if the evidence isn't examined.

Moreover, the MHRA has made no commitment to ever investigate any Yellow Card reports on the effects of the jabs. All it will continue to do is highlight possible safety issues, note the reports, and maybe discuss these with other national regulators. There is no expressed intention to question the manufacturers' hyperbolic claims for the jabs.

The MHRA contends it has a dedicated team that looks for "signals" in the data and that, where a signal is found, the team will discuss it with selected experts. Given that the agency acknowledges both the underreporting and the current monitoring system, which suggests the jabs have a mortality rate orders of magnitude worse than any vaccine, you would imagine that it would have identified a very concerning "signal" by now. Indeed, MHRA officials admit: "Yellow Cards in isolation are sufficient to allow signal detection."

Yet the MHRA has chosen not to use the Yellow Cards as an "early warning." There is no record of MHRA authorities following up on any Yellow Card reports. Instead, what they do is apply a number of relative risk calculations to see if the signal is worthy of further discussion.

In particular, they use the MaxSPRT (Sequential Probability Ratio Test). This compares reported ADRs to the general population—or background—risk of the

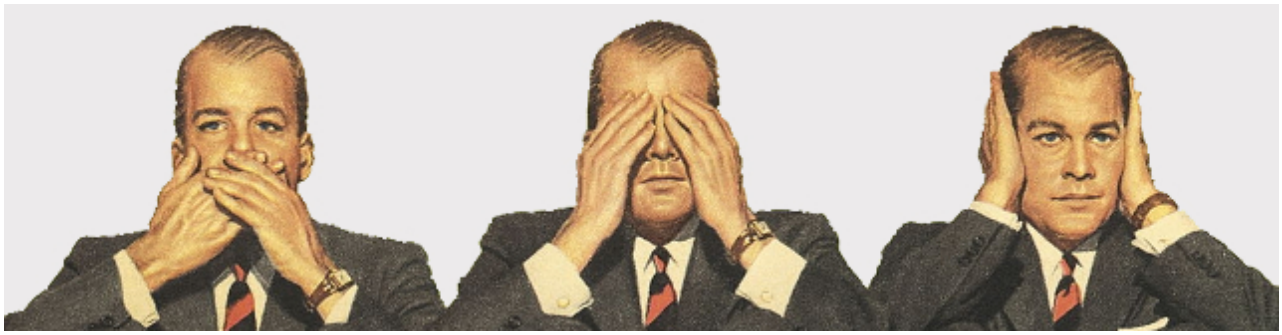
same adverse event. If the likelihood ratio test (LRT) indicates that the risk is higher following a jab, then a signal has been identified.

However, dishonesty lurks within this approach. How so? MaxSPRT is based upon a series of assumptions about the data. Specifically, it assumes that the data is constantly monitored in real time and that there is a matched exposure between the jabbed and the unjabbed to contrast incident rates. But when we are talking about 40M jabbed versus 7M unjabbed adults, the disparity between them and the size of the jabbed and the unjabbed cohorts invalidates this methodology.

Many biostatiticians have pointed out the limitations of using MaxSPRT for large volume database analysis:

"This particular LRT, which conditions on the total number of events, is designed for the rare event case in which only one event is expected to be observed per exposure. [. . .] However, when events are not extremely rare, or when the probability within a stratum of more than one event occurring is not small, the assumptions of this LRT are violated."

In other words, the MHRA appraisal is highly sensitive to extremely rare ADRs but is likely to hide, rather than reveal, the more common side effects that are killing people. The MHRA uses a system that obscures serious problems with the jabs. The only signals its dedicated team might discuss with experts are those that are "extremely rare." The team won't see any signals for more common adverse events and can therefore overlook the obvious and ignore the danger.



MHRA – Dedicated Team

Presumably this is why the MHRA has chosen not to use the "Yellow Cards in isolation." Yet the raw data clearly indicates huge reason for concern. The data has to be reworked and remodelled in order for the MHRA to ignore the glaringly evident. Again, this is a common feature of all jab safety monitoring (pharmacovigilance) systems, which scientists have described as "utterly inadequate."

Correlation does not prove causation, although, where correlation is persistent and pronounced, the chance of it not demonstrating causation diminishes rapidly. Wherever we look, the jabs appear to be causing severe ADRs on an alarming scale.

There is no evidence to substantiate any official or MSM claims about COVID-19 jabs being efficacious or safe. These are experimental drugs with unknown risk profiles, and they are being forced upon people without offering them any opportunity for informed consent—that is, to be informed of the dangers before they give their consent. The jab rollouts breach numerous international conventions, including the Nuremberg Code.

What data does exist is alarming, to say the least, and all the indications are that the jabs are extremely dangerous. There is no doubt that they can kill. Those who support a jab mandate are advocating that people should be forced to take a potentially lethal injection. Anyone who is aware of this fact understandably does not wish to take them.

For their rational reluctance, they are demonised by the government, by the MSM and by a large percentage of those who have elected to be jabbed. If the unvaxxed try to raise any concerns, they are dismissed as antivaxxers, conspiracy theorists, COVID deniers or dangerous refuseniks—and, even more disheartening, are accused of being selfish. How odd. For it is this irrational obsession with the jab that is destroying public health and medical services.

There is clear evidence of obfuscation and denial with intent to hide the dangers of the jabs from the public. The secrecy appears to cross the threshold of criminality in nearly every nation-state where the jabs are deployed. National

populations are clearly under attack by their own governments and by these public entities' private partners.

However, perhaps the most insidious aspect of the jabs is their central role within a new system of governmental authority that is enslaving humanity. Our jab status is the license we now require to participate in a technocratic, behavioural control and surveillance grid. Not only will our vaccine passport (app) monitor and report where we go, who we meet and what we are allowed to do, it will also determine what services we can access.

Those who think the jabs are essential to protect themselves and others against a low mortality respiratory virus have not been given—or choose to ignore—the information required to make this judgement. They believe that they are free because they can now register to use the services that hitherto were freely available to all. They have accepted that they need permission from the government simply to conduct normal, everyday activities.

They are committed to take whatever drugs are given to them for the rest of their lives. If they wish to retain their societal permits, there is no room for negotiation. Their imaginary freedom is conditional upon their continued compliance.

They do not own their own body and are no longer, in any sense, free. They are elective slaves who are seemingly content to condemn future generations, including their own children, to the same fate.

COVID JABS: INEFFECTIVE, OPPRESSIVE AND DANGEROUS

I extend my gratitude to my editor, who has provided invaluable contributions to my articles since October 2021 (but who, for personal reasons, prefers to remain anonymous).

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